| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER: 155383 | | (X2) MULTIPLE CO A. BUILDING B. WING | 00 | (X3) DATE SURVEY COMPLETED 04/08/2011 | |
|---|---------------------|---|---------------|---|-----------|
| NAME OF I | PROVIDER OR SUPPLIE | R | | ADDRESS, CITY, STATE, ZIP CODE / WASHINGTON ST | |
| WASHIN | GTON HEALTH CA | ARE CENTER | | IAPOLIS, IN46231 | |
| (X4) ID | | STATEMENT OF DEFICIENCIES | ID | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E | |
| PREFIX TAG | · ` | NCY MUST BE PERCEDED BY FULL R LSC IDENTIFYING INFORMATION) | PREFIX TAG | CROSS-REFERENCED TO THE APPROP DEFICIENCY) | |
| F0000 | REGULATORT OF | CLSC IDENTIFTING INFORMATION) | IAG | | DATE |
| 1,0000 | 1 | | | | |
| | | or a Recertification and | F0000 | | |
| | State Licensure | Survey. | | | |
| | Survey dates: A | pril 3, 4, 5, 6, 7 & 8, 2011 | | | |
| | Facility number: | . 000393 | | | |
| | Provider number | | | | |
| | AIM number: 1 | | | | |
| | | 00_050.0 | | | |
| | Survey team: | | | | |
| | Marcy Smith RN TC | | | | |
| | Diane Dierks RI | | | | |
| | (April 3, 4, 5, 6 | | | | |
| | Leia Alley RN | , | | | |
| | Patti Allen RN | | | | |
| | (April 3, 4, 5, 6 | & 7. 2011) | | | |
| | (| | | | |
| | Census bed type | : | | | |
| | SNF/NF: 84 | | | | |
| | Total: 84 | | | | |
| | | | | | |
| | Census payor ty | pe: | | | |
| | Medicare: 14 | - | | | |
| | Medicaid: 55 | | | | |
| | Other: 15 | | | | |
| | Total: 84 | | | | |
| | | | | | |
| | Sample: 17 | | | | |
| | Supplemental sa | imple: 2 | | | |
| | | | | | |
| | These deficienci | ies also reflect state | | | |
| | findings in accor | rdance with 410 IAC 16.2. | | | |
| | | | | | |
| LABORATOR | Y DIRECTOR'S OR PRO | VIDER/SUPPLIER REPRESENTATIVE'S SIC | NATURE | TITLE | (X6) DATE |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: MHPP11 Facility ID: 000393

| STATEMEN | STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA | | (X2) MULTIPLE CONSTRUCTION | | | (X3) DATE SURVEY | |
|---------------|--|--|--|--------|---|--|------------|
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER: | A. BUILDING 00 COMPLE | | | ETED | |
| | | 155383 | B. WIN | | | 04/08/2 | 011 |
| | | | D. (111) | | ADDRESS, CITY, STATE, ZIP CODE | | |
| NAME OF I | PROVIDER OR SUPPLIER | | | 8201 W | / WASHINGTON ST | | |
| | WASHINGTON HEALTH CARE CENTER | | | INDIAN | IAPOLIS, IN46231 | | |
| (X4) ID | SUMMARY STATEMENT OF DEFICIENCIES | | | ID | PROVIDER'S PLAN OF CORRECTION | | (X5) |
| PREFIX | 1 | CY MUST BE PERCEDED BY FULL | | PREFIX | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY) | E | COMPLETION |
| TAG | REGULATORY OR | LSC IDENTIFYING INFORMATION) | | TAG | DEFICIENCY) | | DATE |
| F0253 SS=E | Williams, RN The facility must p maintenance servi a sanitary, orderly Based on observa facility failed to e maintenance serv maintain a clean and to ensure fur. This actually afferesiding in the r 211, 303, 301, 30 affected 41 reside East Central Short Findings include During the "Gene conducted with the Supervisor and H supervisor, on 4- a.m., the followin 1) In resident roo table veneer was The base was ma This over bed table resident in this roo over bed table veneer bed table veneer was | eral Observation" tour the Maintenance Housekeeping/Laundry 4-11 beginning at 8:40 ang was observed: om number 211 over bed cracked and scratched. arred and discolored. ole was used by one | F0 | 253 | What corrective action(s) will be accomplished for those Reside found to have been affected by the deficient practice? All over tables were inspected on 4/7/1 and will be reinspected by 4/2 to ensure no further concerns related to cleanliness, scratched or cracks in veneer, or bases discolored or marred. Rooms 301 and 303 were deep cleaned and organized by staff and Resident in room with permiss from the Residents. Rooms 30 and 303 are being cleaned dail by housekeeping staff to included usting, sweeping, mopping, cleaning of all surfaces. Show rooms are cleaned twice daily housekeeping staff. Nursing streevived inservice education regarding infection control and appropriate cleaning of showe rooms following each Resident shower on 4/13, 4/17, and 4/19. Housekeeping and Maintenance staff will be re-educated on 4/27/11 by Housekeeping Supervisor and Director of Housekeeping Services during inservice regarding housekeeping services providing and maintaining a clean daintaining and maintaining and | ents y bed 11 7/11 es ed ion 11 ly de rer by tafff r t 9. ce | 04/29/2011 |

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED 00 A. BUILDING 155383 04/08/2011 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 8201 W WASHINGTON ST WASHINGTON HEALTH CARE CENTER INDIANAPOLIS, IN46231 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE discolored. At the window bed, there was The inservice will include but not limited to maintenance and repair a narrow path that lead into a narrow of overbed tables, maintenance circle path to the resident's bed. The and repair of walls, cleanliness of floor was covered with papers, books, Resident rooms, and shower rooms, Resident personal items totes, and boxes. The chair, window sill, and devices such as lap buddies, and over bed table were covered with the and infection control. Social same type of items. There was an Services will also inservice accumulation of dirt and dust on these housekeeping and maintenance items throughout that side of the room. staff on 4/27/11 regarding Resident behavior referrals and There were 2 residents that share this Resident preferences in relation room. to cleaning times of room. How will you identify other Residents 3) In resident room number 301 door bed. having the potential to be affected by the same deficient practice? lap buddy was soiled with multiple color All Residents have the potential to and size stains. The over bed table veneer be affected by this alleged was cracked and missing. The base was deficient practice. What measures will be put into place or marred and discolored. At the window what systematic changes you will bed, there was a narrow path that lead to make to ensure that the deficient the resident's bed. The floor was covered practice does not with books, baskets, and boxes. The recur?Housekeeping and chair, window sill, and over bed table Maintenance staff will be re-educated on 4/27/11 by were covered with the same type of items. Housekeeping Supervisor and There was an accumulation of dirt and Director of Housekeeping during dust on these items throughout that side of inservice regarding housekeeping the room. There were 2 residents that and maintenance services providing and maintaining a clean share this room. and sanitary environment, and to ensure furniture in good repair. During interview on 4-4-11 at 9:40 a.m., The inservice will include but not with Housekeeping Supervisor who limited to maintenance and repair of overbed tables, maintenance indicated the staff was unable to clean the and repair of walls, cleanliness of rooms 301, 303 properly because Resident rooms, and shower residents would not allow staff to move rooms, Resident personal items the items. and devices such as lap buddies, and infection control.

Facility ID:

| AND PLAN OF CORRECTION IDENTIFICATION NUMBER | | | (X3) DATE SURVEY COMPLETED |
|--|---|--|--|
| | 155383 | 155383 B. WING | 04/08/2011 |
| NAME OF PROVIDER OR SI | | STREET ADDRESS, CITY, STATE, ZIP CODE 8201 W WASHINGTON ST INDIANAPOLIS, IN46231 | • |
| WASHINGTON HEAL (X4) ID SUM PREFIX (EACH DI TAG REGULAT 4) In reside the fan had and dust of By the win areas in the 1" by 1/2", There were room. 5) In reside bed tables and missin discolored used by bo were 2 resi 6) In the E walls were room in mi were grayi walls and d and there we floor of 1 d room was a | TH CARE CENTER MARY STATEMENT OF DEFICIENCIES EFICIENCY MUST BE PERCEDED BY FULL DRY OR LSC IDENTIFYING INFORMATION ent room number 309 door bed, a heavy accumulation of dirt the cover guards and blades. dow bed, there were 3 gouged e drywall above wall protector, 2" by 1/2" and 1/2" by 1". 2 residents that share this ent room number 319, two over eveneer was cracked, scratched g. The bases were marred and The over bed tables were the residents in this room. There dents that share this room. ast Hall Central Shower Room, soiled throughout the shower altiply color and size. There sh/black fingerprints on the loor, 2 of 2 shower stalls had iscarded gloves on the drains, was formed, dried feces on the of 2 shower stalls. This shower used for 41 residents who lived | RESUPPLIER REALTH CARE CENTER RUMMARY STATEMENT OF DEFICIENCIES BUMMARY STATEMENT OF DEFICIENCIES BUMPARY STATEMENT OF DEFICIENCIES BUPPAGRE BEFICIENCY BERCIC CORRECTION SECULO BERCH CORRECTION SECULO BEFICIENCY Social Services will also instends to desire the housekeeping and maintenal staff on 4/27/11 regarding Resident behavior referrals a Resident behavior referral | ervice nce and ion and |
| LPN # 8 in soiled, and on 1 of 2 s unaware he | dicated the shower stalls were that it was formed, dried feces nower stall floors. She was ow long the shower room had | condition of walls, window sill and furniture. One-on-one re-education and/or discipling action may occur for non-compliance. 2 shower stall floors. She was the how long the shower room had alled and with the dried feces. | |

| STATEMEN | T OF DEFICIENCIES | X1) PROVIDER/SUPPLIER/CLIA | (X2) MULTIPLE CO | ONSTRUCTION | (X3) DATE SURVEY |
|-----------|--|---|------------------|---|------------------|
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER: | A. BUILDING | 00 | COMPLETED |
| | | 155383 | B. WING | | 04/08/2011 |
| | | | | ADDRESS, CITY, STATE, ZIP CODE | |
| NAME OF F | PROVIDER OR SUPPLIER | | 8201 W | / WASHINGTON ST | |
| WASHIN | GTON HEALTH CA | RE CENTER | INDIAN | IAPOLIS, IN46231 | |
| (X4) ID | SUMMARY STATEMENT OF DEFICIENCIES | | ID | PROVIDER'S PLAN OF CORRECTION | (X5) |
| PREFIX | | CY MUST BE PERCEDED BY FULL | PREFIX | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA | |
| TAG | | LSC IDENTIFYING INFORMATION) | TAG | DEFICIENCY) | DATE |
| | 3.1-19(f) | | | | |
| F0272 | periodically a com | conduct initially and apprehensive, accurate, oducible assessment of apprehensional capacity. | | | |
| | assessment of a r RAI specified by the must include at lea | demographic information; e; | | | |
| | Mood and behavior Psychosocial well Physical functioning Continence; Disease diagnosist Dental and nutritic Skin conditions; Activity pursuit; Medications; Special treatments Discharge potentic Documentation of regarding the add | being; ng and structural problems; and health conditions; anal status; s and procedures; al; summary information itional assessment the resident assessment | | | |
| SS=D | record review the the feet were pro resulted in open residents reviewe | ation, interview and e facility failed to ensure perly assessed, which foot wounds for 2 of 6 ed for foot care in a esidents # 6, # 63) | F0272 | What corrective action(s) will be accomplished for those Reside found to have been affected be the deficient practice? License nurses will be re-educated in inservice by Director of Nursin Services on 4/26/11 on facility policy for skin management. Licensed nurses perform weel | ents y d |

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED 00 A. BUILDING 155383 04/08/2011 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 8201 W WASHINGTON ST WASHINGTON HEALTH CARE CENTER INDIANAPOLIS, IN46231 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE Findings included: skin assessments on all Residents with or without alterations in skin integrity. CNAs A facility policy, dated 3/10, titled "Skin will be re-educated in inservice by Management Program," provided by the Director of Nursing on 4/26/11 on facility policy for skin Executive Director on 4/5/11 at 8:40 a.m., management. Any skin included, but was not limited to, the alterations, including bruises, following: open areas, redness, skin tears, blisters and rashes during daily "...It is the policy of (name of facility) to care and/or shower days will be reported to the licensed nurse for assess each resident to determine the risk assessment. Shower reports will of potential skin integrity impairment, be signed daily by the CNA upon admission, quarterly, annually, and performing care and the licensed with significant change. Residents will nurse. Director of Nursing Services will oversee proper have a skin assessment completed no less utilization of shower reports. How than weekly by the licensed nurse in an will you identify other Residents effort to assess overall skin condition, having the potential to be affected by the same deficient practice? skin integrity, and skin impairment...All All Residents have the potential to alterations in skin integrity will be be affected by this alleged documented in one of two skin evaluation deficient practice. What reports depending on what type of wound measures will be put into place or - either pressure wound (white) or other what systematic changes you will make to ensure that the deficient wound (lavender)...Pressure reduction practice does not recur?Licensed devices are to be put in place nurses will be re-educated in immediately...The licensed nurse will inservice by Director of Nursing notify the wound nurse of any alterations Services on 4/26/11 on facility policy for skin management. in skin integrity...The facility assigned Licensed nurses will perform wound nurse will complete a further weekly skin assessments on all evaluation of the wounds identified...The Residents with or without care plan will be initiated to include alterations in skin integrity. CNAs will be re-educated in inservice by specific alteration in skin Director of Nursing on 4/26/11 on integrity...Weekly skin assessments will facility policy for skin be completed on all residents with or management. Any skin without alterations in skin integrity and alterations, including bruises, open areas, redness, skin tears, documented on the weekly skin

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

MHPP11 Facility ID:

000393

If continuation sheet

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| AND PLAN OF CORRECTION AND PLAN OF CORRECTION 155383 | | (X2) MULTI A. BUILDIN B. WING | | NSTRUCTION 00 | (X3) DATE S COMPL 04/08/2 | ETED | | |
|--|---|---|---|-----------------|---|--|----------------------------|--|
| | F PROVIDER OR SUPPLIEI | | STREET ADDRESS, CITY, STATE, ZIP CODE 8201 W WASHINGTON ST INDIANAPOLIS, IN46231 | | | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIEN | STATEMENT OF DEFICIENCIES ACY MUST BE PERCEDED BY FULL LISC IDENTIFYING INFORMATION) | | O EFIX AG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | ΓE | (X5) COMPLETION DATE | |
| | care givers during shower days mulicensed nurse for include bruises, tears, blisters, and nurse is responsible all skin alteration direst caregivers reportedThe III team) will do rowassess all wound in the wound medicility must have nurse that assess weekly basis. 1. The record rewas reviewed or Diagnoses for Rewere not limited dementia-uncompatrial fibrillation aphasia, hyperlification, predepression, ceredebility-failure to dysarthria and the Aquarterly Mingassessment, with | alterations noted by direct and daily care and/or st be reported to the or further assessment, to open areas, redness, skin and rashesThe licensed lible for assessing any and ans as reported by the on the shift of (interdisciplinary unds on a weekly basis to als following the guidelines betting guidelinesThe are an assigned wound less the wounds on a leview for Resident # 6 in 4/4/11 at 4:00 p.m. | | | blisters and rashes during dail care and/or shower days will be reported to the licensed nurse assessment. Shower reports be signed daily by the CNA performing care and the license nurse. Director of Nursing Services will oversee proper utilization of shower reports. Wound nurse or designee will rounds weekly to assess all wounds. Wound nurse or Director of Nursing Services wereview all shower reports wee to determine appropriate skin assessment by licensed nurse. How the corrective action(s) will be monitored to ensure the deficient practice whot recur, i.e. what quality assurance program will be put into place? A skin management program CQI tool will be utilized weekly x 4 weeks, then month thereafter to ensure compliance. The CQI committee will review the data. If threshold is not achieved an action plan will be developed, one-on-one re-education and/or disciplinate action may occur for noncompliance. | do do dill kly be de | | |

PRINTED: 05/04/2011 FORM APPROVED OMB NO. 0938-0391

| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA | | (X2) MULTIPLE CONSTRUCTION | | | (X3) DATE SURVEY | | |
|--|--|----------------------------|---------|----------|--|---------|------------|
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER: | A. BUII | LDING | 00 | COMPL | |
| | | 155383 | B. WIN | | | 04/08/2 | 011 |
| NAME OF I | PROVIDER OR SUPPLIER | | | STREET A | ADDRESS, CITY, STATE, ZIP CODE | • | |
| NAME OF I | ROVIDER OR SOLI EIER | | | 1 | / WASHINGTON ST | | |
| WASHINGTON HEALTH CARE CENTER | | RE CENTER | | INDIAN | IAPOLIS, IN46231 | | |
| (X4) ID | SUMMARY S | TATEMENT OF DEFICIENCIES | | ID | PROVIDER'S PLAN OF CORRECTION | | (X5) |
| PREFIX | (EACH DEFICIENCY MUST BE PERCEDED BY FULL | | | PREFIX | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA | ATE | COMPLETION |
| TAG | REGULATORY OR LSC IDENTIFYING INFORMATION) | | _ | TAG | DEFICIENCY) | | DATE |
| | | 4/7/11 at 10:44 a.m., | | | | | |
| | | ident was at risk of | | | | | |
| | | ure ulcers, but had no | | | | | |
| | unhealed pressur | e ulcers. | | | | | |
| | A 1141 | n nuchlana data t | | | | | |
| | • | n problem, dated | | | | | |
| | | ted Resident # 6 was at | | | | | |
| | | kdown or further skin | | | | | |
| | | o: poor mobility, | | | | | |
| | | oowel and bladder, | | | | | |
| | anemia, slides do | | | | | | |
| | 1 ^ ~ | on and diagnosis of | | | | | |
| | 1 ^ | oproaches for this | | | | | |
| | 1 * | d, but were not limited | | | | | |
| | | position every two hours, | | | | | |
| | | nent skin condition | | | | | |
| | weekly and as ne | - | | | | | |
| | 1 ` ′ | of abnormal findings, | | | | | |
| | pressure redistrib | oution mattress on bed, | | | | | |
| | pressure redistrib | oution cushion in | | | | | |
| | wheelchair, and f | float heels while in | | | | | |
| | bed" | | | | | | |
| | | | | | | | |
| | 1 | blem, dated 3/14/2011, | | | | | |
| | | nt #6 had impaired skin | | | | | |
| | 1 | re ulcer on left foot | | | | | |
| | · · | right foot according to | | | | | |
| | | record review), related to | | | | | |
| | 1 - | continence of bowel and | | | | | |
| | | impaired cognition and | | | | | |
| | diagnosis of mali | nutrition. Approaches for | | | | | |
| | this problem, inc | luded, but were not | | | | | |
| | limited to, "trea | atment as ordered, | | | | | |
| | pressure redistrib | oution mattress in bed, | | | | | |

000393

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA | | (X2) MU | JLTIPLE CO | NSTRUCTION | (X3) DATE | SURVEY | |
|---|--|------------------------------|------------|------------|--|---------|------------|
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER: | A. BUII | DING | 00 | COMPL | ETED |
| | | 155383 | B. WIN | | | 04/08/2 | 011 |
| | | | B. WIIV | | ADDRESS, CITY, STATE, ZIP CODE | l | |
| NAME OF 1 | PROVIDER OR SUPPLIEF | 8 | | l | WASHINGTON ST | | |
| WASHIN | GTON HEALTH CA | RE CENTER | | l | APOLIS, IN46231 | | |
| (X4) ID | SUMMARY STATEMENT OF DEFICIENCIES | | | ID | PROVIDER'S PLAN OF CORRECTION | | (X5) |
| PREFIX | (EACH DEFICIEN | ICY MUST BE PERCEDED BY FULL | | PREFIX | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA | ΓE | COMPLETION |
| TAG | REGULATORY OR LSC IDENTIFYING INFORMATION) | | | TAG | DEFICIENCY) | | DATE |
| | pressure redistril | oution cushion in chair, | | | | | |
| | observe for signs | s of infection, assess | | | | | |
| | for pain, notify | MD of worsening or no | | | | | |
| | | d or signs of infection, | | | | | |
| | 1 - | ent to eat at least 75% of | | | | | |
| | meals" | in to out at loast 7570 of | | | | | |
| | 111Ca15 | | | | | | |
| | Facility document | nts, titled "Shower | | | | | |
| | Reports", indica | ted the resident had no | | | | | |
| | | or the dates of 3/2, 3/5, | | | | | |
| | 3/9, and 3/12/2011. The shower reports | | | | | | |
| | | oody mapping diagram | | | | | |
| | | he front, back, sides of | | | | | |
| | | feet. The body mapping | | | | | |
| | 1 - | | | | | | |
| | _ | dates of 3/2, 3/5, 3/9, and | | | | | |
| | • | o areas marked that | | | | | |
| | | sues. The shower report | | | | | |
| | | 16/11, indicated, "No | | | | | |
| | new skin issues. | Problems with her toes." | | | | | |
| | The feet outline | on the body mapping | | | | | |
| | diagram was ma | rked with an "X" on each | | | | | |
| | foot to indicate s | kin issues were noted. | | | | | |
| | | | | | | | |
| | Facility document | nts, titled "Weekly Skin | | | | | |
| | 1 - | or the dates of 3/1 and | | | | | |
| | | ed Resident # 6 had no | | | | | |
| | open skin areas. | | | | | | |
| | 1 ^ | • | | | | | |
| | _ | rt for the date of 3/15/11 | | | | | |
| | | (open area) to R (right) | | | | | |
| | | ently has tx (treatment) | | | | | |
| | order." | | | | | | |
| | | | | | | | |
| | A facility docum | ent titled, "Pressure | | | | | |
| | Wound Evaluation | on Report", included, but | | | | | |

| STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: | | (X2) MULTIPLE CONSTRUCTION (X3) DATE SU COMPLET COMPLET | | | | | |
|--|--|---|--------|--------|--|----------|------------|
| AND PLAN | OF CORRECTION | 155383 | A. BUI | | | 04/08/20 | |
| | | 133300 | B. WIN | | PRESIDENCE CONTROL CON | 04/00/20 | J11 |
| NAME OF I | PROVIDER OR SUPPLIER | | | | ADDRESS, CITY, STATE, ZIP CODE WASHINGTON ST | | |
| WASHIN | GTON HEALTH CA | RE CENTER | | 1 | APOLIS, IN46231 | | |
| (X4) ID | SUMMARY STATEMENT OF DEFICIENCIES | | | ID | | 1 | (X5) |
| PREFIX | (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | | | PREFIX | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE | | COMPLETION |
| TAG | | | | TAG | CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY) | IE. | DATE |
| | was not limited to, the following | | | | | | |
| | information regarding the foot wound: | | | | | | |
| | | | | | | | |
| | 3/14/11 indicated | l: stage IV, length 1.0, | | | | | |
| | width 0.9, depth | unstageable, no | | | | | |
| | tunneling. | | | | | | |
| | | l: stage II, length 0.5, | | | | | |
| | · * | 0.1, no tunneling and | | | | | |
| | improved. | | | | | | |
| | 3/29/11 indicated: stage II, length 0.5, width 0.5, depth less than 0.1, no | | | | | | |
| | | | | | | | |
| | tunneling and improved. | | | | | | |
| | A 1: . 4 | | | | | | |
| | | ess note dated 3/14/11 | | | | | |
| | | s not limited to, the | | | | | |
| | following: | | | | | | |
| | "Podiatric | | | | | | |
| | diagnoses:onyo | chomycosisulcerright | | | | | |
| | second toeUnk | nown duration, nursing | | | | | |
| | had not noticed y | vet. Band-Aid was intact | | | | | |
| | when it was seen | wound location: right | | | | | |
| | second toe1 cer | ntimeter by 1 | | | | | |
| | centimeter(dep | th)to bonewound stage: | | | | | |
| | pressure wound: | | | | | | |
| | IIIpre-debriden | | | | | | |
| | sloughexudate: | • | | | | | |
| | serousperiwoui | | | | | | |
| | hyperkeratotic | erythematousundermini | | | | | |
| | ng: | | | | | | |
| | yeslocationpe | | | | | | |
| | | % sloughexudate: | | | | | |
| | ~ | nguineousodor: | | | | | |
| | noneperiwound | d: clearundermining: | | | | | |

000393

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155383 | | A. BUILE | (X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING | | | (X3) DATE SURVEY COMPLETED 04/08/2011 | |
|---|--|---|--|--------------------|---|---------------------------------------|----------------------------|
| | PROVIDER OR SUPPLIER | | B. WING | STREET A | DDRESS, CITY, STATE, ZIP CODE WASHINGTON ST APOLIS, IN46231 | 0 1100/20 | • |
| (X4) ID PREFIX TAG | (EACH DEFICIEN | TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION) | P | ID REFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | TE (| (X5) COMPLETION DATE |
| | ordered Santyl 2 likely osteomyel now, may need I for long term" | veeks, then Bactroban, itis, oral antibiotic for V (intravenous) antibiotic | | | | | |
| | nurse practitione included, but was following: | | | | | | |
| | done to rule out i Done 3/14: no fra or sclerotic bone painTreated Sa | ow up right foot x-ray, infection of second digit. acture/dislocation or lytic lesionpatient denies ntyl times 2 weeks, then during podiatric visit rted Levaquin | | | | | |
| | A radiology report, dated 3/14/11 included, but was not limited to the following: | | | | | | |
| | second digittyp footImpression sclerotic bone les infection cannot there is no fractu or sclerotic bone infection cannot | e: right foot. No lytic or sion is seen however be ruled outComment: re or dislocation. No lytic lesion is seen however be ruled out" | | | | | |
| | A physician telep | phone order, dated | | | | | |

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155383 | | A. BUI | LDING | ONSTRUCTION 00 | (X3) DATE : COMPL 04/08/2 | ETED | |
|---|--|--|--------|-----------------|--|----------|--------------------|
| | | | B. WIN | | ADDRESS, CITY, STATE, ZIP CODE | 0 1/00/2 | · · · |
| NAME OF I | PROVIDER OR SUPPLIER | | | 1 | WASHINGTON ST | | |
| WASHIN | GTON HEALTH CA | RE CENTER | | INDIAN | APOLIS, IN46231 | | |
| (X4) ID | | TATEMENT OF DEFICIENCIES | | ID | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE | | (X5) |
| PREFIX TAG | ` | CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION) | | PREFIX TAG | CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | ATE. | COMPLETION DATE |
| | | a.m., indicated " 1. | | | | | |
| | | right second toe at ulcer | | | | | |
| | 1 * | g daily times 2 weeks, 2. | | | | | |
| | | tyl after 2 weeks, 3. At 2 | | | | | |
| | weeks switch to | Bactroban with dry | | | | | |
| | dressing daily tin | nes 4 weeks or until | | | | | |
| | healed, 4. Levaqı | uin 500 milligrams, 1 tab | | | | | |
| | (tablet) by mouth | daily times 10 days 5. | | | | | |
| | X-ray right foot, | 2 views (at least)" | | | | | |
| | Nurses notes, dated 3/14/11 (no time listed) indicated, "Podiatrist visit this | | | | | | |
| | | | | | | | |
| | l ' ' | pen area) noted on top of | | | | | |
| | · ` ` | toe. N.O.(new orders) | | | | | |
| | - | inue to observe" | | | | | |
| | | | | | | | |
| | Interdisciplinary | team progress notes, | | | | | |
| | dated 3/17/11, in | dicated the following, | | | | | |
| | "IDT met to revi | ew wounds, area noted on | | | | | |
| | ` | l foot is right foot per | | | | | |
| | | record review), second | | | | | |
| | | present on toe, callous | | | | | |
| | • • | t, wound bed noted with | | | | | |
| | | nk wound edges, no | | | | | |
| | _ | Denies pain/discomfort | | | | | |
| | | sit. Santyl applied and | | | | | |
| | | dressing every day times | | | | | |
| | | itamin with mineral | | | | | |
| | ' ' ' | note wound healing, | | | | | |
| | | illigrams, 1 by mouth | | | | | |
| | | note wound healing. | | | | | |
| | | vn on 3/16/11 results | | | | | |
| | 17.10Awaiting | response from MD" | | | | | |
| | <u> </u> | | | | <u>L</u> | | |

| OMPLETED |
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| 08/2011 |
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| (X5) |
| COMPLETION |
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| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA | | (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVE | | | SURVEY | | |
|--|--|--|---------|--------|---|---------|---------------|
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER: | A. BUII | DING | 00 | COMPL | ETED |
| | | 155383 | B. WIN | | | 04/08/2 | 011 |
| | | | B. WIIV | | ADDRESS, CITY, STATE, ZIP CODE | | |
| NAME OF P | ROVIDER OR SUPPLIER | | | l | WASHINGTON ST | | |
| WASHIN | GTON HEALTH CA | RE CENTER | | l | APOLIS, IN46231 | | |
| (X4) ID | | TATEMENT OF DEFICIENCIES | | ID | PROVIDER'S PLAN OF CORRECTION | | (X5) |
| PREFIX | | CY MUST BE PERCEDED BY FULL | | PREFIX | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT | E | COMPLETION |
| TAG | | LSC IDENTIFYING INFORMATION) | + | TAG | DEFICIENCY) | | DATE |
| | | been told by the resident's | | | | | |
| | | esident does rub her feet | | | | | |
| | together at times | , but she had never | | | | | |
| | observed this, as | she had just transferred | | | | | |
| | to this unit yester | rday. | | | | | |
| | | • | | | | | |
| | During an interv | iew with the Assistant | | | | | |
| | _ | ing (ADON) on 4/4/11 at | | | | | |
| | | DON indicated he thought | | | | | |
| | | • | | | | | |
| | the area where the wound had developed had originally been a calloused area. | | | | | | |
| | nad originally be | en a canoused area. | | | | | |
| | During an interv | iew with the DON on | | | | | |
| | 4/5/11 at 11:00 a.m., the DON indicated | | | | | | |
| | Resident # 6 had seen the podiatrist as a | | | | | | |
| | | osteomyelitis had been | | | | | |
| | | | | | | | |
| | _ | ny. She indicated there | | | | | |
| | | on of a corn/calloused | | | | | |
| 00.5 | area. | ND 11 11/0 | | | NA// | _ | 0.4/2.0/2.044 |
| SS=D | | Resident #63 was | | | What corrective action(s) will be accomplished for those Reside | | 04/29/2011 |
| | reviewed on 3/5/ | 11 at 9:50 am. | | | found to have been affected by | | |
| | | | | | the deficient practice?Licensed | | |
| | Diagnoses for Re | esident #63 included, but | | | nurses will be re-educated in | | |
| | were not limited | to, right heel wound, | | | inservice by Director of Nursing | g | |
| | congestive heart | failure, altered mental | | | Services on 4/26/11 on facility | | |
| | status and encepl | halopathy. | | | policy for skin management. Licensed nurses perform week | dv | |
| | | | | | skin assessments on all | чy | |
| | Resident #63 wa | s originally admitted to | | | Residents with or without | | |
| | | 19/11 and readmitted | | | alterations in skin integrity. CN | | |
| | _ | | | | will be re-educated in inservice | | |
| | after a hospital stay on 2/10/11. | | | | Director of Nursing on 4/26/11 facility policy for skin | on | |
| | An admission nu | rsing assessment | | | management. Any skin | | |
| | | 10/11 indicated the | | | alterations, including bruises, | | |
| | • | uise on his left upper arm | | | open areas, redness, skin tear | s, | |
| | resident had a br | uise on his left upper arm | | | | | |

| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA | | | | | | (X3) DATE SURVEY |
|--|---|------------------------------|---------|--------|---|------------------|
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER: | A. BUII | LDING | 00 | COMPLETED |
| | | 155383 | B. WIN | | | 04/08/2011 |
| | | | D. WIIV | | ADDRESS, CITY, STATE, ZIP CODE | |
| NAME OF I | PROVIDER OR SUPPLIER | | | | / WASHINGTON ST | |
| MACHIN | GTON HEALTH CA | DE CENTED | | 1 | IAPOLIS, IN46231 | |
| | | | | | | |
| (X4) ID | | TATEMENT OF DEFICIENCIES | | ID | PROVIDER'S PLAN OF CORRECTION | (X5) |
| PREFIX | ` | CY MUST BE PERCEDED BY FULL | | PREFIX | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA | |
| TAG | | LSC IDENTIFYING INFORMATION) | | TAG | DEFICIENCY) | DATE |
| | and a small amount of non-pitting edema | | | | blisters and rashes during dail | |
| | in his right foot. On a body mapping | | | | care and/or shower days will be reported to the licensed nurse | |
| | diagram, include | ed in the assessment, | | | assessment. Shower reports | II |
| | " | e circled. The diagram | | | be signed daily by the CNA | VVIII |
| | | where problems on the | | | performing care and the licens | sed |
| | | et could be documented. | | | nurse. Director of Nursing | |
| | | | | | Services will oversee proper | |
| | | eas marked to indicate | | | utilization of shower reports. I | |
| | the resident had a | • | | | will you identify other Residen | |
| | discolorations, pr | ressure sores or open | | | having the potential to be affect | II |
| | areas. | | | | by the same deficient practice | |
| | | | | | All Residents have the potenti be affected by this alleged | ai to |
| | A "Pressure Wou | nd Risk Assessment," | | | deficient practice. What | |
| | | 1, indicated the resident | | | measures will be put into place | e or |
| | was "at risk for d | | | | what systematic changes you | |
| | | leveloping skin | | | make to ensure that the deficie | |
| | breakdown." | | | | practice does not recur?Licens | sed |
| | | | | | nurses will be re-educated in | |
| | A care plan for R | esident #63, dated | | | inservice by Director of Nursin | |
| | 2/24/11 with a G | oal Target Date of | | | Services on 4/26/11 on facility | |
| | 5/24/11 indicated | l a problem of "Potential | | | policy for skin management. Licensed nurses will perform | |
| | for skin breakdov | wn related to: edema, | | | weekly skin assessments on a | |
| | | y, slides down in bed, | | | Residents with or without | " |
| | | imes, impaired cognition, | | | alterations in skin integrity. Cl | NAs |
| | ' ' | , 1 | | | will be re-educated in inservice | |
| | | he goal was "Will have | | | Director of Nursing on 4/26/11 | on |
| | no skin breakdov | • • | | | facility policy for skin | |
| | · | y skin checks by LN" | | | management. Any skin | |
| | (Licensed Nurse) | and "CNA to do skin | | | alterations, including bruises, | |
| | check with show | er and notify LN of | | | open areas, redness, skin teal blisters and rashes during dail | |
| | abnormals." | | | | care and/or shower days will b | · |
| | uonominus. | | | | reported to the licensed nurse | II |
| | Weekly Skin Assessments completed | | | | assessment. Shower reports | II |
| | Weekly Skin Assessments completed | | | | be signed daily by the CNA | |
| | 2/14/11, 2/21/11 and 2/28/11 by RN (Registered Nurse) #1 indicated the | | | | performing care and the licens | sed |
| | | | | | nurse. Director of Nursing | |
| | resident had no skin tears, open areas, | | | | Services will oversee proper | |
| | marks, bruises, d | iscolorations or rashes. | | | utilization of shower reports. | |

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: | | (X2) M | ULTIPLE CC | ONSTRUCTION | (X3) DATE S COMPL | | |
|---|--|------------------------------|-----------------------|-------------|--|---------|------------|
| AND PLAN | OF CORRECTION | 155383 | A. BUII | | 00 | 04/08/2 | |
| | | 100000 | B. WIN | | A DDDEGG CITY GTATE ZIR CODE | 04/00/2 | 011 |
| NAME OF | PROVIDER OR SUPPLIEI | ₹ | | 1 | ADDRESS, CITY, STATE, ZIP CODE WASHINGTON ST | | |
| WASHIN | IGTON HEALTH CA | RE CENTER | INDIANAPOLIS, IN46231 | | | | |
| (X4) ID | SUMMARY S | STATEMENT OF DEFICIENCIES | | ID | PROVIDENCE N. AV OF CORRECTION | | (X5) |
| PREFIX | (EACH DEFICIEN | NCY MUST BE PERCEDED BY FULL | | PREFIX | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT | TE. | COMPLETION |
| TAG | REGULATORY OR | LSC IDENTIFYING INFORMATION) | | TAG | DEFICIENCY) | | DATE |
| | | nts did not have a diagram | | | Wound nurse or designee will | do | |
| | of the body or fe | eet to indicate whether the | | | rounds weekly to assess all wounds. Wound nurse or | | |
| | resident's feet w | ere assessed. | | | Director of Nursing Services w | rill | |
| | | | | | review all shower reports weel | | |
| | Nurses' Notes fo | or 3/6/11 indicated the | | | to determine appropriate skin | | |
| | | have complaints of | | | assessment by licensed nurse.How the corrective | | |
| | | o "blister to (R)[right] | | | action(s) will be monitored to | | |
| | heel." | | | | ensure the deficient practice w | /ill | |
| | | | | | not recur, i.e. what quality | | |
| | | or 3/7/11 indicated "Blister | | | assurance program will be put into place? A skin managemen | | |
| | to (R) heel intac | t - dark red in color" | | | program CQI tool will be utilize | | |
| | | | | | weekly x 4 weeks, then month | ly | |
| | 1 | n Assessment completed | | | thereafter to ensure compliand | | |
| | 3/7/11 indicated | the resident had no skin | | | The CQI committee will review the data. If threshold is not | ′ | |
| | 1 | s, marks, bruises, | | | achieved an action plan will be | , | |
| | | rashes. This assessment | | | developed, one-on-one | | |
| | 1 | ody mapping diagram to | | | re-education and/or disciplinar | У | |
| | | the resident's feet were | | | action may occur for noncompliance. | | |
| | assessed. | | | | noncompliance. | | |
| | Shower reports | on which Certified | | | | | |
| | 1 - | nts (CNA) would have | | | | | |
| | 1 | oblem skin areas, were | | | | | |
| | 1 | esident #63 on 4/7/11 at | | | | | |
| | _ ^ | 5 pm the DON indicated | | | | | |
| | 1 ^ | ower sheets because the | | | | | |
| | | using to take a shower. | | | | | |
| | 1 | this time the CNA's do | | | | | |
| | | ort sheet, where they | | | | | |
| | would document any problem skin areas, | | | | | | |
| | 1 | ceives a bath or bathing | | | | | |
| | assistance in their room | | | | | | |
| | | | | | | | |
| | Further informat | tion was requested from | | | | | |

PRINTED: 05/04/2011 FORM APPROVED OMB NO. 0938-0391

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155383 | | (X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING | | | (X3) DATE SURVEY COMPLETED 04/08/2011 | | | |
|---|--|--|---|-----------------|--|----------------------------|------------|--|
| | PROVIDER OR SUPPLIER | | STREET ADDRESS, CITY, STATE, ZIP CODE 8201 W WASHINGTON ST INDIANAPOLIS, IN46231 | | | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIEN | TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION) | PRE | D EFIX AG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY) | (X5) COMPLETION DATE | | |
| | pm regarding wh Assessment dated Resident #63 had blister and wheth completed this as the resident's feet indicated she did no documentation | y the Weekly Skin d 3/7/11 did not indicate d developed a right heel der RN #1, who desessment, had checked to At this time she not know why there was n on the blister. She no longer worked at the | | | | | | |
| F0314 SS=D | a resident, the factoresident who enterpressure sores do sores unless the indemonstrates that and a resident have receives necessar promote healing, prevent new sores Based on observative record review, the residents who residents review 4 residents review 4 | ation, interview and e facility failed to ensure sided in the facility t pressure ulcers for 2 of wed for foot care in a sidents # 6, # 63). | F0314 | 4 | What corrective action(s) will be accomplished for those Reside found to have been affected by the deficient practice? Licensed nurses and CNAs will be re-educated on prevention of avoidable pressure sores and necessary treatment services promote healing, prevent infection, and prevent new sor | ents y d to | 04/29/2011 | |
| | A facility policy, | dated 3/10, titled "Skin | | | from developing. Re-educatio will be accomplished through | n | | |

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

MHPP11 Facility ID:

000393

If continuation sheet

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155383 | (X2) MULTIPLE C A. BUILDING B. WING | ONSTRUCTION 00 | (X3) DATE SURVEY COMPLETED 04/08/2011 | | |
|---|--|--|--|--|--|--|
| NAME OF PROVIDER OR SUPPLI | | STREET ADDRESS, CITY, STATE, ZIP CODE 8201 W WASHINGTON ST INDIANAPOLIS, IN46231 | | | | |
| PREFIX (EACH DEFICI | STATEMENT OF DEFICIENCIES SNCY MUST BE PERCEDED BY FULL OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | (X5) COMPLETION DATE | | |
| Executive Dire included, but we following: "It is the politication of potential skin upon admission with significant have a skin assess than weekly by effort to assess skin integrity, alterations in sedocumented in reports dependent to either pressure wound (lavened devices are to limmediately') notify the wou in skin integrit wound nurse we evaluation of the care plan will be specific alterate integrity Week be completed of without alterate documented on assessment for notesAny skin skin sales and the political specific alterate documented on assessment for notesAny skin skin sales and the political specific alterate documented on assessment for notesAny skin sales are assessment specific alterate documented on assessment for notesAny skin sales are assessment specific alterate documented on assessment for notesAny skin sales are assessment specific alterate documented on assessment specific alterate documented specific alterate | The licensed nurse will and nurse of any alterations yThe facility assigned ill complete a further ne wounds identifiedThe pe initiated to include | | inservice by Director of Nursir Services on 4/26/11. How will identify other Residents havin the potential to be affected by same deficient practice? All Residents have the potential to be affected by this alleged deficient practice. What measures will be put into place what systematic changes you make to ensure that the defici practice does not recur? Licen nurses and CNAs will be re-educated on prevention of avoidable pressure sores and necessary treatment services promote healing, prevent infection, and prevent new so from developing. Re-education will be accomplished through inservice by Director of Nursir Services on 4/26/11. Wound nurse or designee will do rour weekly to assess all wounds. Wound nurse or Director of Nursing Services will review a shower reports weekly to determine appropriate skin assessment by licensed nurse. How the corrective action(s) will be monitored to ensure the deficient practice wout recur, i.e. what quality assurance program will be puinto place? A skin managemer CQI tool will be used weekly weeks, then monthly thereafted ensure compliance. The CQI committee will review data. If threshold is not achieved an action plan will be developed, one-on-one re-education and/ | l you g the do | | |

| l l | | (X2) MULTIPLE CO | | (X3) DATE SURVEY COMPLETED | |
|-----------|----------------------|-------------------------------|-------------|---|------------|
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER: 155383 | A. BUILDING | 00 | 04/08/2011 |
| | | 100000 | B. WING | A DEPARTMENT OF CORP. | 04/00/2011 |
| NAME OF I | PROVIDER OR SUPPLIER | | | ADDRESS, CITY, STATE, ZIP CODE / WASHINGTON ST | |
| WASHIN | GTON HEALTH CA | RE CENTER | l l | IAPOLIS, IN46231 | |
| (X4) ID | SUMMARY S | TATEMENT OF DEFICIENCIES | ID | | (X5) |
| PREFIX | (EACH DEFICIEN | CY MUST BE PERCEDED BY FULL | PREFIX | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA | COMPLETION |
| TAG | REGULATORY OR | LSC IDENTIFYING INFORMATION) | TAG | DEFICIENCY) | DATE |
| | 1 | at be reported to the | | disciplinary action may occur | for |
| | | r further assessment, to | | noncompliance. | |
| | · · | open areas, redness, skin | | | |
| | | d rashesThe licensed | | | |
| | · • | ble for assessing any and | | | |
| | | as as reported by the | | | |
| | direst caregivers | | | | |
| | _ | OT (interdisciplinary | | | |
| | l ' | ands on a weekly basis to | | | |
| | | s following the guidelines | | | |
| | | eting guidelinesThe | | | |
| | | e an assigned wound | | | |
| | | es the wounds on a | | | |
| | weekly basis. | | | | |
| | A facility policy. | dated 5/2008, titled | | | |
| | | ng AssistantPosition | | | |
| | | ovided by the DON | | | |
| | | sing) on 4/5/2011 at 2:33 | | | |
| | l ' | ut was not limited to, the | | | |
| | following: | , | | | |
| | | | | | |
| | | Nursing Assistant | | | |
| | ^ | and nursing related | | | |
| | | ents consistent with each | | | |
| | · | ehensive assessment and | | | |
| | plan of careEss | • | | | |
| | | ng - assists transporting | | | |
| | | shower, washes/rinses | | | |
| | | es body thoroughly with | | | |
| | | le maintaining privacy | | | |
| | | timesObserves and | | | |
| | | orts to Unit Charge | | | |
| | Nurse, unusual o | ccurrences, significant | | | |

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155383 | | A. BUIL | DING | NSTRUCTION 00 | (X3) DATE S COMPL 04/08/2 | ETED | |
|---|---|---|---------|---------------------|--|---------|----------------------------|
| NAME OF F | PROVIDER OR SUPPLIER | | B. WINC | STREET A | DDRESS, CITY, STATE, ZIP CODE | 04/06/2 | 011 |
| WASHIN | GTON HEALTH CA | RE CENTER | | | WASHINGTON ST APOLIS, IN46231 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIEN | TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION) | 1 | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | ΤE | (X5) COMPLETION DATE |
| | changes in resident's physical or behavioral condition" | | | | | | |
| | changes in resident's physical or | | | | | | |
| | | view for Resident # 6 4/4/11 at 4:00 p.m. | | | | | |
| | Diagnoses for Re | esident # 6 included, but | | | | | |

| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: | | (X2) M | ULTIPLE CO | ONSTRUCTION | (X3) DATE S COMPLI | | |
|--|---|---|------------|--------------|--|----------|--------------------|
| AND PLAN | OF CORRECTION | 155383 | A. BUII | LDING | 00 | 04/08/20 | |
| | | 100000 | B. WIN | | | 04/06/20 | 711 |
| NAME OF I | PROVIDER OR SUPPLIER | | | | ADDRESS, CITY, STATE, ZIP CODE WASHINGTON ST | | |
| WASHIN | GTON HEALTH CA | RE CENTER | | 1 | APOLIS, IN46231 | | |
| | _ | | | | 1 | | 215 |
| (X4) ID PREFIX | | TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL | | ID PREFIX | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE | | (X5) COMPLETION |
| TAG | · ` | LSC IDENTIFYING INFORMATION) | | TAG | CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | TE | DATE |
| - | were not limited | · · · · · · · · · · · · · · · · · · · | | _ | | | |
| | | plicated, hypertension, | | | | | |
| | atrial fibrillation, intracranial hemorrhage, | | | | | | |
| | | idemia, uremia, severe | | | | | |
| | dehydration, pne | | | | | | |
| | 1 - | provascular accident, | | | | | |
| | _ | thrive, malnutrition, | | | | | |
| | dysarthria and th | | | | | | |
| | | iomoodytopema. | | | | | |
| | A quarterly Mini | mum Data Set (MDS) | | | | | |
| | 1 1 | an assessment reference | | | | | |
| | · · | rovided by the MDS | | | | | |
| | · · · | /7/11 at 10:44 a.m., | | | | | |
| | | dent was at risk of | | | | | |
| | | ure ulcers, but had no | | | | | |
| | unhealed pressur | | | | | | |
| | | | | | | | |
| | A health care pla | n problem, dated | | | | | |
| | 1 | ed Resident # 6 was at | | | | | |
| | risk for skin brea | kdown or further skin | | | | | |
| | breakdown due to | o: poor mobility, | | | | | |
| | | owel and bladder, | | | | | |
| | anemia, slides do | · | | | | | |
| | · · | on and diagnosis of | | | | | |
| | malnutrition. Ap | proaches for this | | | | | |
| | | d, but were not limited | | | | | |
| | _ | position every two hours, | | | | | |
| | | nent skin condition | | | | | |
| | weekly and as ne | eded, notify MD | | | | | |
| | 1 - | of abnormal findings, | | | | | |
| | · ' | oution mattress on bed, | | | | | |
| | pressure redistrib | | | | | | |
| | wheelchair, and t | float heels while in | | | | | |
| | bed" | | | | | | |

| | STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155383 | | A. BUI | (X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING | | | (X3) DATE SURVEY COMPLETED 04/08/2011 | |
|--------------------------|--|--|--------|--|---|--|---------------------------------------|----------------------------|
| | PROVIDER OR SUPPLIE | | D. WII | STREET AI | DDRESS, CITY, STA WASHINGTON APOLIS, IN4623 | ST | | |
| | | | | <u> </u> | 41 OLIO, 114 4 020 | , i | | |
| (X4) ID PREFIX TAG | (EACH DEFICIEN | STATEMENT OF DEFICIENCIES NCY MUST BE PERCEDED BY FULL R LSC IDENTIFYING INFORMATION) | | ID PREFIX TAG | (EACH CORRECTIV CROSS-REFERENCE | LAN OF CORRECTION E ACTION SHOULD BE ED TO THE APPROPRIATE ICIENCY) | : | (X5) COMPLETION DATE |
| | indicated Reside integrity: Pressu (affected foot is observation and poor mobility, ir bladder, anemia diagnosis of mal this problem, inclimited to, "tre pressure redistril pressure redistril observe for signs for pain, notify change in wound encourage reside meals" | oblem, dated 3/14/2011, ent #6 had impaired skin are ulcer on left foot right foot according to record review), related to accordinence of bowel and impaired cognition and lutrition. Approaches for cluded, but were not eatment as ordered, bution mattress in bed, bution cushion in chair, s of infection, assess y MD of worsening or no d or signs of infection, ent to eat at least 75% of | | | | | | |
| | Reports", indicate new skin areas from 3/9, and 3/12/20 also included a by which outlined to the body and the diagrams for the 3/12/2011, had round indicated skin is for the date of 3/1 new skin issues. The feet outline diagram was manual from the skin issues. | ents, titled "Shower atted the resident had no for the dates of 3/2, 3/5, 11. The shower reports body mapping diagram the front, back, sides of the feet. The body mapping at dates of 3/2, 3/5, 3/9, and no areas marked that assues. The shower report 1/6/11, indicated, "No Problems with her toes." on the body mapping arked with an "X" on each skin issues were noted. | | | | | | |
| FORM CMS-2 | 2567(02-99) Previous Version | ions Obsolete Event ID: | MHPP1 | 1 Facility II | D: 000393 | If continuation she | et Pa | ge 22 of 39 |

| STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: | | (X2) MI A. BUII | | NSTRUCTION 00 | (X3) DATE S | ETED | |
|--|---|---|--------|---------------|---|---------|------------|
| | | 155383 | B. WIN | | | 04/08/2 | 011 |
| NAME OF I | PROVIDER OR SUPPLIER | | | | ADDRESS, CITY, STATE, ZIP CODE | | |
| WASHIN | GTON HEALTH CAI | RE CENTER | | 1 | WASHINGTON ST APOLIS, IN46231 | | |
| (X4) ID | SUMMARY S | TATEMENT OF DEFICIENCIES | | ID | PROVIDER'S PLAN OF CORRECTION | | (X5) |
| PREFIX | · | CY MUST BE PERCEDED BY FULL | | PREFIX | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA | TE | COMPLETION |
| TAG | REGULATORY OR | LSC IDENTIFYING INFORMATION) | _ | TAG | DEFICIENCY) | | DATE |
| | Facility document Assessments", for 3/8/2011 indicated open skin areas. assessment report indicated, "O/A (second toe. Curre order." A facility document Wound Evaluation was not limited to information regards 3/14/11 indicated width 0.9, depth tunneling. 3/22/11 indicated width 0.5, depth improved. 3/29/11 indicated width 0.5, depth tunneling and immaked A podiatry progresincly but was following: "Podiatric diagnoses:onycosecond toeUnktoe" | ats, titled "Weekly Skin or the dates of 3/1 and ed Resident # 6 had no The weekly skin t for the date of 3/15/11 dopen area) to R (right) ently has tx (treatment) ent titled, "Pressure on Report", included, but to, the following riding the foot wound: 1: stage IV, length 1.0, unstageable, no 1: stage II, length 0.5, 0.1, no tunneling and 1: stage II, length 0.5, less than 0.1, no | | | | | |
| | when it was seen | wound location: right | | | | | |

| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: | | (X2) MU | JLTIPLE CO | NSTRUCTION | (X3) DATE S COMPL | | |
|--|--------------------------------------|---|------------|------------|--|----------|------------|
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER: 155383 | A. BUIL | | 00 | 04/08/20 | |
| | | 100000 | B. WINC | | DDDEGG CITY GTATE ZID CODE | 04/00/20 | 711 |
| NAME OF F | PROVIDER OR SUPPLIER | | | | ADDRESS, CITY, STATE, ZIP CODE WASHINGTON ST | | |
| WASHIN | GTON HEALTH CA | RE CENTER | | | APOLIS, IN46231 | | |
| (X4) ID | | TATEMENT OF DEFICIENCIES | | ID | PROVIDER'S PLAN OF CORRECTION | | (X5) |
| PREFIX | ` | CY MUST BE PERCEDED BY FULL | | PREFIX | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY) | TΕ | COMPLETION |
| TAG | | LSC IDENTIFYING INFORMATION) | | TAG | DEFICIENCY) | | DATE |
| | second toe1 cer | • | | | | | |
| | centimeter(depth)to bonewound stage: | | | | | | |
| | pressure wound: | 1000/ | | | | | |
| | IIIpre-debriden | | | | | | |
| | sloughexudate: | • | | | | | |
| | serousperiwoui | | | | | | |
| | | erythematousundermini | | | | | |
| | ng: | | | | | | |
| | yeslocationpe | | | | | | |
| | | % sloughexudate: | | | | | |
| | _ | nguineousodor: | | | | | |
| | | d: clearundermining: | | | | | |
| | | piotic and bandage, | | | | | |
| | | weeks, then Bactroban, | | | | | |
| | 1 ' | itis, oral antibiotic for | | | | | |
| | | V (intravenous) antibiotic | | | | | |
| | for long term" | | | | | | |
| ı | A physician prog | ress note, signed by a | | | | | |
| | nurse practitione | r, with a date of 3/18/11, | | | | | |
| | included, but was | s not limited to the | | | | | |
| ı | following: | | | | | | |
| | - | | | | | | |
| | | w up right foot x-ray, | | | | | |
| | | infection of second digit. | | | | | |
| | | acture/dislocation or lytic | | | | | |
| | | lesionpatient denies | | | | | |
| | 1 ^ | ntyl times 2 weeks, then | | | | | |
| | | during podiatric visit | | | | | |
| | 3/14/11, who star | rted Levaquin | | | | | |
| | treatment" | | | | | | |
| | | | | | | | |
| | A radiology repo | | | | | | |
| | included, but was | s not limited to the | | | | | |

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Event ID:

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000393

If continuation sheet

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| AND PLAN OF CORRECTION IDENTIFICATION NUMBER: | | (X2) MULTIPLE CONSTRUCTION (X3) DATE S A PHILEDRIC 00 COMPLE | | | | | |
|---|----------------------|---|------------------|---------------|--|---------|--------------------|
| 111,212,11 | or conditions | 155383 | A. BUI B. WIN | LDING | | 04/08/2 | |
| | | | B. WIN | | DDRESS, CITY, STATE, ZIP CODE | | |
| NAME OF F | PROVIDER OR SUPPLIER | | | | WASHINGTON ST | | |
| WASHIN | GTON HEALTH CA | RE CENTER | | INDIAN | APOLIS, IN46231 | | |
| (X4) ID | | TATEMENT OF DEFICIENCIES | | ID | PROVIDER'S PLAN OF CORRECTION | | (X5) |
| PREFIX TAG | , i | CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION) | | PREFIX TAG | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY) | ΤE | COMPLETION DATE |
| IAG | following: | LSC IDENTIFTING INFORMATION) | | IAG | | | DATE |
| | Tollowing. | | | | | | |
| | "reason for exa | am: rule out infection of | | | | | |
| | second digittyp | | | | | | |
| | footImpression | : right foot. No lytic or | | | | | |
| | sclerotic bone les | sion is seen however | | | | | |
| | | be ruled outComment: | | | | | |
| | | re or dislocation. No lytic | | | | | |
| | | lesion is seen however | | | | | |
| | infection cannot | be ruled out" | | | | | |
| | Ahi.aia 4.a1a | | | | | | |
| | 1 ^ * * * * * | ohone order, dated a.m., indicated " 1. | | | | | |
| | | right second toe at ulcer | | | | | |
| | 1 * | g daily times 2 weeks, 2. | | | | | |
| | ' | ryl after 2 weeks, 3. At 2 | | | | | |
| | | Bactroban with dry | | | | | |
| | | nes 4 weeks or until | | | | | |
| | " | uin 500 milligrams, 1 tab | | | | | |
| | · · · | daily times 10 days 5. | | | | | |
| | X-ray right foot, | 2 views (at least)" | | | | | |
| | | | | | | | |
| | l ' | ted 3/14/11 (no time | | | | | |
| | · | "Podiatrist visit this | | | | | |
| | ` | pen area) noted on top of | | | | | |
| | ~ | toe. N.O.(new orders) | | | | | |
| | notedWill cont | inue to observe" | | | | | |
| | Interdisciplinary | team progress notes, | | | | | |
| | 1 . | dicated the following, | | | | | |
| | l ' | ew wounds, area noted on | | | | | |
| | | I foot is right foot per | | | | | |
| | ` | record review), second | | | | | |
| | | present on toe, callous | | | | | |

| STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: | | | | INSTRUCTION 00 | (X3) DATE : COMPL | | |
|--|--|--|------------------|----------------|--|---------|--------------------|
| | | 155383 | A. BUI B. WIN | | | 04/08/2 | 011 |
| | | | b. Will | | ADDRESS, CITY, STATE, ZIP CODE | | |
| NAME OF I | PROVIDER OR SUPPLIER | | | 1 | WASHINGTON ST | | |
| | GTON HEALTH CAI | | | INDIAN | APOLIS, IN46231 | | |
| (X4) ID | | TATEMENT OF DEFICIENCIES | | ID | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE | | (X5) |
| PREFIX TAG | ` | CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION) | | PREFIX TAG | CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | TE | COMPLETION DATE |
| 1710 | 1 | t, wound bed noted with | + | mo | · | | DATE |
| | | ik wound edges, no | | | | | |
| | drainage noted. Denies pain/discomfort | | | | | | |
| | | sit. Santyl applied and | | | | | |
| | | dressing every day times | | | | | |
| | 1 | itamin with mineral | | | | | |
| | | note wound healing, | | | | | |
| | 1 , , , | illigrams, 1 by mouth | | | | | |
| | | note wound healing. | | | | | |
| | 1 ' ' ' | vn on 3/16/11 results | | | | | |
| | 17.10Awaiting response from MD" | | | | | | |
| | | 1 | | | | | |
| | On 4/5/11 at 10:55 a.m., the following | | | | | | |
| | observation was | _ | | | | | |
| | | | | | | | |
| | Nurse # 2 entered | d the room of Resident # | | | | | |
| | 6. She was weari | ng a gown, gloves and | | | | | |
| | feet coverings du | e to isolation precautions | | | | | |
| | were posted on a | sign outside the door. | | | | | |
| | Nurse # 2 indicat | ted the roommate of | | | | | |
| | Resident # 6 had | previously had | | | | | |
| | Clostridium Diffi | icile, but the roommate | | | | | |
| | was now asympto | omatic and antibiotics | | | | | |
| | 1 | ted. The isolation | | | | | |
| | l ^ | still in place as a | | | | | |
| | * · | easure for a few weeks. | | | | | |
| | The nurse remov | ed the old dressing. A | | | | | |
| | small amount of | light green/brown | | | | | |
| | _ | nall amount of blood was | | | | | |
| | l ^ | d dressing. The outer | | | | | |
| | _ | nd were pink and the | | | | | |
| | | and was more of a | | | | | |
| | | ere was a pin-point area | | | | | |
| | of depth at the ce | enter of the wound. The | | | | | |

PRINTED: 05/04/2011 FORM APPROVED OMB NO. 0938-0391

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER: 155383 | | (X2) MULTIPLE CO A. BUILDING B. WING | NSTRUCTION 00 | (X3) DATE SURVEY COMPLETED 04/08/2011 | |
|---|--|--|---------------------|---|----------------------|
| | PROVIDER OR SUPPLIER | | STREET A 8201 W | ADDRESS, CITY, STATE, ZIP CODE WASHINGTON ST APOLIS, IN46231 | |
| (X4) ID PREFIX TAG | (EACH DEFICIEN | TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY) | (X5) COMPLETION DATE |
| | wound to be abore centimeters. The with normal salir applied 2% Bactre the wound with a secured the dress resident indicated. Contact precautic and clean technic throughout the principal principal cannot be allowed and had be family that the restogether at times observed this, as to this unit yester. During an intervioral principal pr | ted the total size of the at 0.5 centimeters by 0.5 nurse cleaned the wound he and dried the area and roban and then covered a dry dressing and ing with paper tape. The dishe had no pain. Ons, standard precautions que were maintained rocedure. The nurse ught the area had been a been told by the resident's esident does rub her feet, but she had never she had just transferred rday. The with the Assistant ing (ADON) on 4/4/11 at DON indicated he thought he wound had developed en a calloused area. The with the DON on the DON indicated seen the podiatrist as a costeomyelitis had been by. She indicated there on of a corn/calloused itew with the DON on the down of a corn/calloused item with the DON on the down of a corn/calloused item with the DON on the down of a corn/calloused item with the DON on the down of a corn/calloused item with the DON on the down of a corn/calloused item with the DON on the down of a corn/calloused item with the DON on the down of a corn/calloused item with the DON on the down of a corn/calloused item with the DON on the down of the d | | | |
| | ~ | m., the DON indicated | | | |

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

MHPP11 Facility ID:

000393

If continuation sheet

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| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155383 | | (X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING | | | (X3) DATE SURVEY COMPLETED 04/08/2011 | | |
|--|---|--|---|--------------------|--|--|----------------------------|
| | PROVIDER OR SUPPLIER | | STREET ADDRESS, CITY, STATE, ZIP CODE 8201 W WASHINGTON ST INDIANAPOLIS, IN46231 | | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIEN | TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION) | Р | ID REFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | ΓE | (X5) COMPLETION DATE |
| SS=D | Resident # 6 word 4/8/11, and the factor of the record of reviewed on 3/5/Diagnoses for Resident #63 was the facility on 1/2 after a hospital stand a small amount in his right foot. diagram, included these 2 areas were included an area bottom of the fee There were no arther resident had a discolorations, prareas. A "Pressure Wourdent of the fee There were word and a small amount in the fee There were no arther exident had a discolorations, prareas. | Resident #63 was 11 at 9:50 am. esident #63 included, but to, right heel wound, failure, altered mental halopathy. soriginally admitted to 19/11 and readmitted eay on 2/10/11. rsing assessment 0/11 indicated the uise on his left upper arm ant of non-pitting edema On a body mapping ed in the assessment, we circled. The diagram where problems on the et could be documented. eas marked to indicate eany blisters, ressure sores or open and Risk Assessment," 1, indicated the resident | | | What corrective action(s) will be accomplished for those Reside found to have been affected be the deficient practice? License nurses and CNAs will be re-educated on prevention of avoidable pressure sores and necessary treatment services promote healing, prevent infection, and prevent new sor from developing. Re-education will be accomplished through inservice by Director of Nursing Services on 4/26/11. How will identify other Residents having the potential to be affected by same deficient practice? All Residents have the potential to be affected by this alleged deficient practice. What measures will be put into place what systematic changes you make to ensure that the deficient practice does not recur? Licentary in the potential to be affected by the pote | ents y d to es y y to es y y the o e or will ent sed to es n | 04/29/2011 |

| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA | | | (X2) M | (X2) MULTIPLE CONSTRUCTION | | | (X3) DATE SURVEY | |
|--|------------------------------------|------------------------------|---------|----------------------------|--|----------|------------------|--|
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER: | A. BUII | DING | 00 | COMPLE | TED | |
| | | 155383 | B. WIN | | | 04/08/20 | 11 | |
| | | | D. WIN | | ADDRESS, CITY, STATE, ZIP CODE | | | |
| NAME OF I | PROVIDER OR SUPPLIER | | | | WASHINGTON ST | | | |
| WASHIN | GTON HEALTH CA | RE CENTER | | | APOLIS, IN46231 | | | |
| | | | | | 74 OLIO, 11440201 | | | |
| (X4) ID | | TATEMENT OF DEFICIENCIES | | ID | PROVIDER'S PLAN OF CORRECTION | | (X5) | |
| PREFIX | ` | CY MUST BE PERCEDED BY FULL | | PREFIX | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY) | TE | COMPLETION | |
| TAG | | LSC IDENTIFYING INFORMATION) | + | TAG | | . + | DATE | |
| | | Resident #63, dated | | | Nursing Services will review a | l | | |
| | 2/24/11 with a G | oal Target Date of | | | shower reports weekly to determine appropriate skin | | | |
| | 5/24/11 indicated | d a problem of "Potential | | | assessment by licensed | | | |
| | for skin breakdov | wn related to: edema, | | | nurse.How the corrective | | | |
| | impaired mobilit | y, slides down in bed, | | | action(s) will be monitored to | | | |
| | | imes, impaired cognition, | | | ensure the deficient practice w | ıill | | |
| | ' ' | he goal was "Will have | | | not recur, i.e. what quality | | | |
| | | vn." Approaches | | | assurance program will be put | | | |
| | | | | | into place?A skin managemen CQI tool will be used weekly x | | | |
| | l . | y skin checks by LN" | | | weeks, then monthly thereafte | | | |
| | l ` ′ | and "CNA to do skin | | | ensure compliance. The CQI | | | |
| | check with shower and notify LN of | | | | committee will review data. If | | | |
| | abnormals." | | | | threshold is not achieved an | | | |
| | | | | | action plan will be developed, | | | |
| | Weekly Skin Ass | sessments completed | | | one-on-one re-education and/ | | | |
| | 2/14/11, 2/21/11 | and 2/28/11 by RN | | | disciplinary action may occur f | or | | |
| | | se) #1 indicated the | | | noncompliance. | | | |
| | | kin tears, open areas, | | | | | | |
| | | iscolorations or rashes. | | | | | | |
| | l ' | | | | | | | |
| | | its did not have a diagram | | | | | | |
| | | et to indicate whether the | | | | | | |
| | resident's feet we | ere assessed. | | | | | | |
| | | | | | | | | |
| | Nurses' Notes for | r 3/6/11 indicated the | | | | | | |
| | resident did not h | nave complaints of | | | | | | |
| | discomfort due to | o "blister to (R)[right] | | | | | | |
| | heel." | · /L O J | | | | | | |
| | | | | | | | | |
| | Nurses' Notes for | r 3/7/11 indicated "Blister | | | | | | |
| | | | | | | | | |
| | io (K) neer mact | - dark red in color" | | | | | | |
| | | | | | | | | |
| | 1 | Assessment completed | | | | | | |
| | | the resident had no skin | | | | | | |
| | tears, open areas, | , marks, bruises, | | | | | | |
| | discolorations or | rashes. This assessment | | | | | | |

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER: 155383 | | (X2) MULTIPLE C A. BUILDING B. WING | ONSTRUCTION 00 | | E SURVEY PLETED 2011 | |
|---|--|---|---------------------|---|----------------------------|----------------------------|
| | PROVIDER OR SUPPLIER | | 8201 \ | ADDRESS, CITY, STATE, ZIP CO W WASHINGTON ST NAPOLIS, IN46231 | DE | |
| (X4) ID PREFIX TAG | (EACH DEFICIEN | TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE AF DEFICIENCY) | OULD BE | (X5) COMPLETION DATE |
| | | | | | | |
| | did not have a body mapping diagram to indicate whether the resident's feet were | | | | | |
| F0323 | | ensure that the resident ins as free of accident | | | | |

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155383 | | (X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING | | | (X3) DATE SURVEY COMPLETED 04/08/2011 | | |
|---|--|---|---------|---------------------|--|--|----------------------------|
| | PROVIDER OR SUPPLIER GTON HEALTH CAI | | D. WILV | STREET A | ADDRESS, CITY, STATE, ZIP CODE / WASHINGTON ST IAPOLIS, IN46231 | ı | |
| (X4) ID PREFIX TAG | (EACH DEFICIEN | TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION) | | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | ΤE | (X5) COMPLETION DATE |
| SS=E | receives adequate assistance devices. Based on observate facility failed to oprotected from protected from prot | sto prevent accidents. Ation and interview, the ensure residents were obtential hazards in their naving side rails in use tential of allowing for een the rails for 8 of 41 ed for having side rails amended measurement mple of 84. (Residents 18, #49, #50, #52 and de: de by the United States administration on Tospital Bed System Assessment Guidance to ent" indicated there an 4 3/4 inches between ide rail supports. Inmental tour with the ector on 4/7/11 at 4:15 g was observed: bed by the window, used had distances of between extween the side rails and | F0 | 323 | What corrective action(s) will accomplished for those Resid found to have been affected be the deficient practice? All beds and siderails were again revie on 4/11/11 by Maintenance Supervisor and maintenance sutilizing Bed Rail Safety Chectool. No further beds were identified to be out of compliant with FDA measurement recommendations or identified have the potential for entrapment. Siderails that we identified to have measureme greater than the FDA measurement recommendation were removed from the premit to avoid future misuse. How you identify other Residents having the potential to be affected by the same deficient practice. All Residents have the potential be affected by this alleged deficient practice. What measures will be put into place what systematic changes you make to ensure that the deficient practice does not recur? Sidenthat were identified to have measurements greater than the FDA measurement recommendations were removed from the premises to avoid fut misuse. An additional review of beds and siderails will be completed by Maintenance Supervisor by 4/28/11 utilizing Bed Rail Safety Check tool | ents y s wed staff k nce to re nts ses will cted r ial to e or will ent ails ne wed ure of all | 04/29/2011 |

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155383 | | (X2) MI A. BUII B. WIN | LDING | NSTRUCTION 00 | (X3) DATE S COMPL 04/08/2 | ETED | |
|--|--|--|-------|---------------------|---|--|----------------------------|
| | PROVIDER OR SUPPLIEF | | | STREET A | ADDRESS, CITY, STATE, ZIP CODE WASHINGTON ST APOLIS, IN46231 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIEN | STATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION) | | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | TE | (X5) COMPLETION DATE |
| | 5 and 7 inches be side rail supports. In room 309, the by Resident #39, 5 and 7 inches be side rail supports. In room 314, the by Resident #48, 5 and 7 inches be side rail supports. In room 315, the Resident #49, and used by Resident between 5 and 7 rails and side rail supports. In room 316, the by Resident #52, 5 and 7 inches be side rail supports. In room 321, the by Resident #62, 5 and 7 inches be side rail supports. During an intervent Director at this to were the older be these side rails. In the older be these side rails. In the older be these side rails. In the older be the ol | between the side rails and s. bed by the window, used had distances of between etween the side rails and s. bed by the window, used had distances of between etween the side rails and s. bed by the door, used by dethe bed by the window, at #50 had distances of inches between the side al supports. bed by the window, used had distances of between the side rails and s. bed by the window, used had distances of between the side rails and s. bed by the window, used had distances of between the side rails and s. bed by the window, used had distances of between the side rails and s. bed by the window, used had distances of between the side rails and s. bed by the window, used had distances of between the side rails and s. bed by the window, used had distances of between the side rails and s. bed by the window, used had distances of between the side rails and s. bed by the window, used had distances of between the side rails and s. bed by the window, used had distances of between the side rails and s. bed by the window, used had distances of between the side rails and s. bed by the window, used had distances of between the side rails and s. bed by the window, used had distances of between the side rails and s. bed by the window, used had distances of between the side rails and s. bed by the window, used had distances of between the side rails and s. bed by the window, used had distances of between the side rails and s. bed by the window, used had distances of between the side rails and s. bed by the window, used had distances of between the side rails and s. bed by the window, used had distances of between the side rails and s. bed by the window, used had distances of between the side rails and s. bed by the window, used had distances of between the side rails and s. bed by the window, used had distances of between the side rails and s. bed by the window, used had distances of between the side rails and s. bed by the window, used had distances of between the side rails and s. bed by the window, used had distances of betw | | | to ensure that the spacing between mattress, bed frame, and gaps are within the FDA measurements. Any side rail is installed to the beds will be assessed to ensure that the rameet FDA measurements priorinstallation. Side rails assessments will ensure that spacing between mattress, be frame, and gaps are within the FDA measurements. How the corrective action(s) will be monitored to ensure the defici practice will not recur, i.e. what quality assurance program will put into place?CQI tool for siderails will be completed monthly x 2 and quarterly thereafter to ensure the sidera are secured properly on the be with appropriate spacing between mattress, bed frame, and gaps fall within FDA measurement recommendations per the Bed Rail Safety Check tool. | that ails r to the d ent t I be sills ed een s | |

PRINTED: 05/04/2011 FORM APPROVED OMB NO. 0938-0391

| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: | | (X2) MULTIPLE A. BUILDING | CONSTRUCTION 00 | (X3) DATE SURVEY COMPLETED | |
|--|---|---|------------------|--|---------------|
| | | 155383 | B. WING | | 04/08/2011 |
| | PROVIDER OR SUPPLIER GTON HEALTH CAI | | STREE 8201 | T ADDRESS, CITY, STATE, ZIP CODE W WASHINGTON ST ANAPOLIS, IN46231 | |
| (X4) ID | SUMMARY S' | TATEMENT OF DEFICIENCIES | ID | PROVIDENC N. AN OF CORRECTION | (X5) |
| PREFIX | (EACH DEFICIEN | CY MUST BE PERCEDED BY FULL | PREFIX | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI | COMPLETION |
| TAG | REGULATORY OR | LSC IDENTIFYING INFORMATION) | TAG | DEFICIENCY) | DATE |
| | the above side ra | ils. | | | |
| | 4/8/11 at 9:50 am potentially hazard immediately rem the daily exit interest Residents #27, 32 had been assessed their side rails we indicated physicial above residents we concern. She indicated physicial above residents we concern. She indicated physicial above residents we concern. She indicated physicials. She indicated physicials. She indicated assistants to see it rails. She indicated Assistants had been the 15 minute check Resident #27 had side rail and this a new bed. She in facility were revial/7/11 and again determine if there | ans and families of the vere notified of the licated therapy was in the ing each of these of they still needed side the Certified Nursing the inserviced regarding the ecks. She indicated a received an order for 1 was provided along with indicated all beds in the ewed at 7:00 pm on at 8:00 am on 4/8/11 to be were any other side the es over 4 3/4 inches | | | |
| F0364 | provides food prep conserve nutritive appearance; and f attractive, and at t | ood that is palatable, he proper temperature. | | | |
| SS=E | Based on observa | ation and interview the | F0364 | What corrective action(s) will | be 04/29/2011 |

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

MHPP11 Facility ID:

000393

If continuation sheet

Page 33 of 39

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA | | | (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY | | | | |
|---|------------------------|----------------------------------|---|--------|--|----------------|------------|
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER: | A BIIII | LDING | 00 | COMPL | ETED |
| | | 155383 | B. WIN | | · | 04/08/2 | 011 |
| | | | D. WIIV | | ADDRESS, CITY, STATE, ZIP CODE | | |
| NAME OF I | PROVIDER OR SUPPLIEF | R | | 1 | WASHINGTON ST | | |
| WYV CHIM | GTON HEALTH CA | DE CENTED | | 1 | APOLIS, IN46231 | | |
| WASHIN | GION HEALTH CA | RE CENTER | | INDIAN | APOLIS, IN40231 | | |
| (X4) ID | | STATEMENT OF DEFICIENCIES | | ID | PROVIDER'S PLAN OF CORRECTION | | (X5) |
| PREFIX | (EACH DEFICIEN | ICY MUST BE PERCEDED BY FULL | | PREFIX | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT | ΓE | COMPLETION |
| TAG | REGULATORY OR | LSC IDENTIFYING INFORMATION) | ļ | TAG | DEFICIENCY) | | DATE |
| | facility failed to | ensure recipes were | | | accomplished for those Reside | | |
| | followed while p | oreparing pureed food in 1 | | | found to have been affected by | y | |
| | | s. This had the potential | | | the deficient practice?Dietary | | |
| | | residents who received | | | cooks will be re-educated thro | - | |
| | | | | | inservice on 4/28/11 by Dietary | ^y | |
| | 1 ^ | om the kitchen in the | | | Manager and Registered Dietician regarding following o | f | |
| | facility population | on of 84. | | | recipes while preparing pureed | | |
| | | | | | foods. How will you identify of | | |
| | | | | | Residents having the potential | | |
| | Finding Include: | | | | be affected by the same defici | | |
| | | | | | practice? All Residents have t | | |
| | | al observation on 4-4-11 at | | | potential to be affected by this | | |
| | was observed: | lietary manager the following | | | alleged deficient practice. Wh | | |
| | was observed: | | | | measures will be put into place | | |
| | 1) When dietary ste | aff pureed the fish for the | | | what systematic changes you | | |
| | | put fish in and then poured an | | | make to ensure that the deficie | | |
| | | t of hot water from a pitcher. | | | practice does not recur?Dietar | | |
| | | g process the staff added 2 | | | cooks will be re-educated thro inservice on 4/28/11 by Dietary | | |
| | | mounts of hot water from the | | | Manager and Registered | , | |
| | | d not have a recipe out to refer | | | Dietician regarding following o | f | |
| | to. | | | | recipes while preparing pureed | | |
| | | | | | foods. Cooks will demonstrate | | |
| | 2) When dietary sta | aff pureed the pea and carrots | | | through skills validation the ab | ility | |
| | for the evening mea | l, they put peas and carrots in | | | to read recipe, measure | | |
| | and then poured an | unmeasured amount of hot | | | appropriate ingredients per | | |
| | water from a pitche | r. The staff did not have a | | | recipe, and prepare pureed | | |
| | recipe out to refer to | 0. | | | diet. Dietary Manager and | | |
| | | | | | Registered Dietician will provide increased supervision to ensure | | |
| | | ff pureed the chocolate | | | that pureed food is made | i c | |
| | | ning meal, they put chocolate | | | according to the menu. How the | _ | |
| | | poured an unmeasured amount | | | corrective action(s) will be | ~ | |
| | | pitcher. During the pureeing | | | monitored to ensure the deficie | ent l | |
| | 1 ^ | d 1 more unmeasured amount | | | practice will not recur, i.e. wha | | |
| | have a recipe out to | ne pitcher. The staff did not | | | quality assurance program will | be | |
| | nave a recipe out to | icici (U. | | | put into place?Dietary Manage | er | |
| | A) During interes | iou after the puresing process | | | will utilize skills validation for | | |
| | ' | iew after the pureeing process | | | preparing pureed foods for each | ch | |
| | 1 | ger she indicated that the | | | meal weekly x 4 weeks, then | | |
| | tacility does have re | ecipes to follow when | | | monthly x 2. One-on-one | | |

| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA | | (X2) M | ULTIPLE CC | ONSTRUCTION | (X3) DATE S | | |
|--|---|--|------------|---------------|--|--------------------|-----------------|
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER: 155383 | A. BUI | LDING | 00 | COMPLE 04/08/20 | |
| | | 199363 | B. WIN | | | 04/06/20 | 111 |
| NAME OF P | PROVIDER OR SUPPLIER | | | | ADDRESS, CITY, STATE, ZIP CODE | | |
| WYV CHINI | GTON HEALTH CAI | DE CENTED | | 1 | / WASHINGTON ST IAPOLIS, IN46231 | | |
| | | | | | | | |
| (X4) ID | | TATEMENT OF DEFICIENCIES | | ID | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE | | (X5) |
| PREFIX TAG | ` | CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION) | | PREFIX TAG | CROSS-REFERENCED TO THE APPROPRIAT | re | COMPLETION DATE |
| IAG | preparing pureed for | | + | IAG | re-education and/or disciplinar | , | DATE |
| | preparing pureed for | 54. | | | action may occur for | ^y | |
| | She reviewed the fac | cility recipe for the Fish. She | | | noncompliance. | | |
| | | indicated when preparing for 10 the recipe calls | | | | | |
| | | 2 teaspoon of Chicken Base, 3 | | | | | |
| | | 1 1 Tablespoon of 100% lemon | | | | | |
| | | did not refer to the recipe or | | | | | |
| | and any ingredient of amount of hot water | ther than Fish and unmeasured | | | | | |
| | amount of not water | ., | | | | | |
| | She reviewed the fac | cility recipe for the Chocolate | | | | | |
| | | ated when preparing for 10 the | | | | | |
| | * | cup of 2% milk. Dietary staff | | | | | |
| | | ecipe or add any ingredient | | | | | |
| | amount of hot water | e Cookies and unmeasured | | | | | |
| | amount of not water | - | | | | | |
| | She reviewed the fa | cility recipe for the Peas and | | | | | |
| | | ted when preparing for 10 the | | | | | |
| | | cup Margarine Solid. Dietary | | | | | |
| | | the recipe or add any | | | | | |
| | _ | n Peas and Carrots and | | | | | |
| | unmeasured amount | of not water. | | | | | |
| | She indicated that the | e Fish and Peas and Carrots | | | | | |
| | would have had a be | etter flavor if staff would have | | | | | |
| | followed the facility | recipe, measured the correct | | | | | |
| | _ | dients, and added what the | | | | | |
| | | ne Chocolate Cookies would | | | | | |
| | | vor and more nourishment | | | | | |
| | | had the potential to | | | | | |
| | | ts who received pureed | | | | | |
| | | itchen in the facility | | | | | |
| | population of 87. | | | | | | |
| | | | | | | | |
| | 3.1-21(a)(2) | | | | | | |
| E0271 | The facility must - | | | | | | |
| F0371 | | rom sources approved or | | | | | |
| | (1)1100010100011 | | | | | | |

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155383 | | A. BUILDING B. WING O | | | COMPI | X3) DATE SURVEY COMPLETED 04/08/2011 | |
|---|--|---|----|---|---|--------------------------------------|------------|
| | PROVIDER OR SUPPLIER | | • | 8201 V | ADDRESS, CITY, STATE, ZIP CODE V WASHINGTON ST | • | |
| | GTON HEALTH CA | | | INDIAN | NAPOLIS, IN46231 | | |
| (X4) ID | | TATEMENT OF DEFICIENCIES | | ID | PROVIDER'S PLAN OF CORRECTION | | (X5) |
| PREFIX | , | CY MUST BE PERCEDED BY FULL | | PREFIX | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA | ΤE | COMPLETION |
| TAG | | LSC IDENTIFYING INFORMATION) | - | TAG | DEFICIENCY) | | DATE |
| 00.5 | local authorities; a (2) Store, prepare under sanitary cor | , distribute and serve food nditions | | 2-1 | NA/In a to a super stirrer and in a start (a) will be | L - | 24/20/2044 |
| SS=E | | ation and interview, the | FO | 371 | What corrective action(s) will accomplished for those Resid | | 04/29/2011 |
| | | ensure appliances and | | | found to have been affected b | | |
| | | to prepare food were | | | the deficient practice?On 4/13 | - | |
| | clean or maintair | ned in a sanitary condition | | | all pans identifed to have | | |
| | during 1 of 2 kits | chen observations. This | | | substance build up and/or der | nted | |
| | had the potential | to affect 80 residents | | | and pitted exterior or interior sides/bottoms were removed | | |
| | who received me | eals from the kitchen in | | | from the premises to avoid fut | ure | |
| | the facility popul | ation of 84. | | | misuse. Inservice education b | | |
| | Findings Include | : | | Dietary Manager and Registered Dietician will be accomplished on 4/28/11 to re-educate staff on | | | |
| | During the observat | | | | cleaning and maintenance of preparation equipment to inclu | | |
| | | 1 at 3:15 p.m., with the | | | stove cleaning, oven cleaning | | |
| | Dietary Manager the | e following were observed: | | | and other equipment.How will identify other Residents havin | you | |
| | 1) The stove had b | lack and brown burnt on | | | the potential to be affected by | - | |
| | substance on all | 4 burners and visible | | | same deficient practice? All | | |
| | food particles co | vering the top of stove. | | | Residents have the potential t | :0 | |
| | | | | | be affected by this alleged deficient practice. What | | |
| | | or oven had numerous | | | measures will be put into place | | |
| | baked on spills. | | | | what systematic changes you make to ensure that the defici | | |
| | 3) Nine of nine la | ge metal baking sheets | | | practice does not recur?Inser | vice | |
| | · · | and black burned on, | | | education by Dietary Manage | | |
| | | ce on the edges, interior | | | and Registered Dietician will to accomplished on 4/28/11 to | oe . | |
| | and exterior. | or the edges, interior | | | re-educate staff on cleaning a | nd | |
| | and exterior. | | | | maintenance of food preparat | | |
| | 4) Two of two sa | uce different size kettles | | | equipment to include stove | | |
| | · / | a dark brown and black | | | cleaning, oven cleaning, and | | |
| | _ | as burned on to the | | | other equipment. Dietary Manager and Registered | | |
| | | rior and the sides and | | | Dietician will demonstrate pro | per | |
| | micror and exter | ioi and the sides and | | | cleaning techniques. Dietary | r. =: | |

| li ´ | | (X2) M | ULTIPLE CO | ONSTRUCTION | (X3) DATE SURVEY | |
|-------------------|--|--|------------|---------------|--|-------------------------|
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER: 155383 | A. BUI | LDING | 00 | COMPLETED 04/08/2011 |
| | | 100000 | B. WIN | | | 04/06/2011 |
| NAME OF F | PROVIDER OR SUPPLIER | | | | ADDRESS, CITY, STATE, ZIP CODE | |
| WASHIN | GTON HEALTH CA | DE CENTED | | 1 | / WASHINGTON ST APOLIS, IN46231 | |
| | | | | | AF 0LI3, IN40231 | |
| (X4) ID PREFIX | | TATEMENT OF DEFICIENCIES | | ID | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE | (X5) COMPLETION |
| TAG | ` | CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION) | | PREFIX TAG | CROSS-REFERENCED TO THE APPROPRIAT | DATE |
| 1710 | | · · · · · · · · · · · · · · · · · · · | | mo | Manager and Registered | DATE |
| | bottoms of the kettles were dented and pitted. | | | | Dietician will provide increased | i |
| | | | | | supervision to ensuret that iter | |
| | 5) One of one me | edium stock kettle had a | | | that need cleaning are actually | ' |
| | l ' | k brown and black | | | cleaned according to daily cleaning assignments. How the | ا م |
| | | as burned on to the | | | corrective action(s) will be | |
| | | rior and the sides and | | | monitored to ensure the deficie | |
| | | ettles were dented and | | | practice will not recur, i.e. wha | |
| | | and were utility and | | | quality assurance program will put into place?Dietary Manage | |
| | pitted. | | | | and/or Registered Dietician wil | |
| | 6) One of one lor | ge roast pan had a build | | | review appliances and equipm | ent |
| | l ' | yn and black substance | | | weekly x 4 weeks and monthly | ' |
| | 1 ^ | on to the interior and | | | thereafter utilizing Sanitation Checklist to ensure appliances | . |
| | | on to the interior and | | | and equipment used to prepar | |
| | exterior. | | | | food are clean and maintained | |
| | 7) Six of six small a | nd 3 of 3 large muffin pans | | | a sanitary condition. | |
| | | a dark brown and black | | | | |
| | 1 | as burned on to the | | | | |
| | interior and exter | | | | | |
| | | | | | | |
| | 8) Seventeen of sev | renteen different size steam | | | | |
| | _ | ild up of a dark brown | | | | |
| | and black substar | nce that was burned on to | | | | |
| | | exterior and/or the sides | | | | |
| | and bottoms of the | ne kettles were dented | | | | |
| | and pitted. | | | | | |
| | | | | | | |
| | _ | at this time with Dietary | | | | |
| | _ | ted that the baking sheets, pans and skillet were used to | | | | |
| | | residents. She further | | | | |
| | ^ ^ | e above mentioned items | | | | |
| | | to affect the 80 of 84 | | | | |
| | 1 ^ | ng food from the kitchen. | | | | |
| | Testucinis receivir | ng 1000 mom me kitchen. | | | | |
| | | | | | | |

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA | | (X2) MULTIPLE CONSTRUCTION | | | (X3) DATE SURVEY | | |
|---|----------------------|---|----------|--------|---|---------|------------|
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER: | A. BUII | DING | 00 | COMPL | ETED |
| | | 155383 | B. WIN | | | 04/08/2 | 011 |
| | | | D. WIIV | | ADDRESS, CITY, STATE, ZIP CODE | | |
| NAME OF P | ROVIDER OR SUPPLIER | | | | / WASHINGTON ST | | |
| VAVA CLUMA | GTON HEALTH CA | DE CENTED | | | IAPOLIS, IN46231 | | |
| WASHIN | GTON HEALTH CA | RECENTER | | INDIAN | | | |
| (X4) ID | SUMMARY S | TATEMENT OF DEFICIENCIES | | ID | PROVIDER'S PLAN OF CORRECTION | | (X5) |
| PREFIX | (EACH DEFICIEN | CY MUST BE PERCEDED BY FULL | | PREFIX | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT | E | COMPLETION |
| TAG | | LSC IDENTIFYING INFORMATION) | <u> </u> | TAG | DEFICIENCY) | | DATE |
| | 3.1-21(i)(3) | | 1 | | | | |
| F0465 | | provide a safe, functional, | | | | | |
| | | fortable environment for | | | | | |
| | residents, staff and | | | | \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ | | |
| SS=E | | vation and interview, the | F0 | 465 | What corrective action(s) will be | | 04/29/2011 |
| | facility failed to | ensure the kitchen walls, | | | accomplished for those Reside found to have been affected by | | |
| | floors and non-fo | ood preparation | | | the deficient practice?Cleaning | | |
| | equipment was c | lean and in good repair | | | walls, doors, ceilings, fan, tras | • | |
| | | chen observations which | | | cans, and tables was complete | ed | |
| | _ | to affect 80 residents | | | by 4/11/11. Painting of walls a | | |
| | - | from the kitchen in the | | | doors in need of repair was als | | |
| | _ | | | | completed by 4/11/11. Dietary | ' | |
| | | and to affect staff who | | | staff will be re-educated on | | |
| | worked in the die | etary department. | | | 4/28/11 by Dietary Manager ar Registered Dietician with | iu | |
| | | | | | inservice on sanitation of | | |
| | FINDINGS INC | LUDE: | | | non-food preparaton areas and | d | |
| | | | | | equipment, including kitchen | | |
| | - | valk through on 4/3/11 at 1:15 | | | walls, floors, and food prepara | tion | |
| | _ | Cook and Dietary Manager the | | | equipment. How will you ident | tify | |
| | following were obse | erved: | | | other Residents having the | | |
| | 1) The wells and so | ilinga waga gailad with | | | potential to be affected by the | | |
| | | ilings were soiled with I stains. There were multiple | | | same deficient practice? All | _ | |
| | | thing had been removed off | | | Residents have the potential to be affected by this alleged | J | |
| | | ls were not repaired or | | | deficient practice. What | | |
| | | ors in the kitchen had | | | measures will be put into place | e or | |
| | | ation in the center of the doors | | | what systematic changes you | | |
| | 6 3 | andles. The interior of the | | | make to ensure that the deficie | ent | |
| | | so discolored and dirty. | | | practice does not recur?Dietar | y | |
| | | - | | | staff will be re-educated on | | |
| | 2) The fan had heav | y accumulation of black dust | | | 4/28/11 by Dietary Manager ar | nd | |
| | film on the guard co | overs and blades. | | | Registered Dietician with | | |
| | | | | | inservice on sanitation and | | |
| | | located through the kitchen | | | cleaning of non-food preparate areas and equipment, includin | | |
| | | altiple dry colored stains food | | | kitchen walls, floors, and food | 9 | |
| | particles. | | | | preparation equipment. How t | he | |
| | | | | | corrective action(s) will be | | |
| | | ables used to store seasoning, | | | monitored to ensure the deficie | ent | |
| | equipment to prepar | re resident food, coffee, tea | | | practice will not recur, i.e. wha | | |
| | | | | | <u> </u> | | |

| NAME OF PROVIDER OR SUPPLIER WASHINGTON HEALTH CARE CENTER (X4) ID PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION) STREET ADDRESS, CITY, STATE, ZIP CODE R8201 W WASHINGTON ST INDIANAPOLIS, IN46231 ID PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) TAG Quality assurance program will be | | | B. WING | 04/08/2011 | |
|--|---|--|---|---|--|
| PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL PREFIX CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) Product, glasses and plates had a build up dried quality assurance program will be | | | STREET ADDRESS, CITY, STATE, ZIP CODE 8201 W WASHINGTON ST | | |
| paint. During an interview with the dietary manager at the end of the walk through, she indicated she would take care of the above mentioned observations. She indicated the above and/or Registered Dietician will reveiw non-food preparation areas and equipment weekly x 4 weeks then monthly therafter utlizing Sanitation Checklist to ensure walls, ceilings, floors, doors, and equipment are clean | PREFIX (EACH) TAG REGULA product, gla food particl paint. During an i the end of t would tak observation | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) product, glasses and plates had a build up dried food particles, dirt and loose, peeling, missing paint. During an interview with the dietary manager at the end of the walk through, she indicated she would take care of the above mentioned observations. She indicated the above | ID PREFIX TAG PROVIDER'S PLAN OF CORRECTION SHOULD CROSS-REFERENCED TO THE APPROPRIATION SHOULD CROSS-REFERENCED TO THE APPROPROPRIATION SHOULD CROSS-REFERENCED TO THE APPROPRIATION SHOULD CROSS-REFERENCED TO SHOULD CROSS-REFERENCED TO THE APPROPRIATION SHOULD CROSS-REFERENCED TO THE APPROPRIATION SHOULD CROSS-REFERENCED TO SHOULD CROSS-REFERENCED TO THE APPROPRIATION SHOULD CROSS-REFERENCED TO SHOULD CROSS-REFERENCED TO THE APPROPRIATION SHOULD CROSS-REFERENCED TO THE APPROPRIATION SHOULD CROSS-REFERENCED TO | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) Quality assurance program will be put into place? Dietary Manager and/or Registered Dietician will reveiw non-food preparation areas and equipment weekly x 4 weeks then monthly therafter utlizing Sanitation Checklist to ensure walls, ceilings, floors, doors, and equipment are clean | |
| mentioned observations, had the potential to affect 80 residents receiving meals from the kitchen. 3.1-19(f) and in good repair. One-on-one re-education and/or disciplinary action may occur for non-compliance. | to affect 8 from the 1 | to affect 80 residents receiving meals from the kitchen. | re-education and/or discipling action may occur for | | |